



Report to the Subcommittee on
Defense, Committee on
Appropriations, U.S. Senate

January 2015

DEFENSE HEALTH CARE

Additional Information Needed about Mental Health Provider Staffing Needs

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GAO Highlights

Highlights of [GAO-15-184](#), a report to the Subcommittee on Defense, Committee on Appropriations, U.S. Senate

Why GAO Did This Study

Mental health providers are essential to DOD's delivery of health care to servicemembers and other beneficiaries. DOD's need for these providers has grown as increasing numbers of servicemembers experience life-threatening combat situations. This led to congressional attention—such as the NDAA for Fiscal Year 2010, which included provisions to help DOD increase the number of mental health providers it employs.

GAO was asked to review DOD's efforts to increase its mental health provider workforce. Among other objectives, GAO examined (1) how staffing levels changed in response to congressional direction and (2) how DOD and the military services assess current and future needs for mental health providers. GAO reviewed DOD's mental health staffing estimation model and the military services' quarterly mental health provider staffing reports for fiscal years 2009 through 2013, the latest information available. GAO also interviewed DOD and military service officials responsible for assessing mental health staffing needs.

What GAO Recommends

GAO recommends that the military services report on service-specific or supplemental processes for generating mental health provider staffing estimates and that DOD continue to refine its staffing estimation model. DOD generally concurred with these recommendations, but did not concur with two others related to the use of PHRAMS that are also included in the report. GAO continues to believe these recommendations are valid as discussed further in the report.

View [GAO-15-184](#). For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov.

January 2015

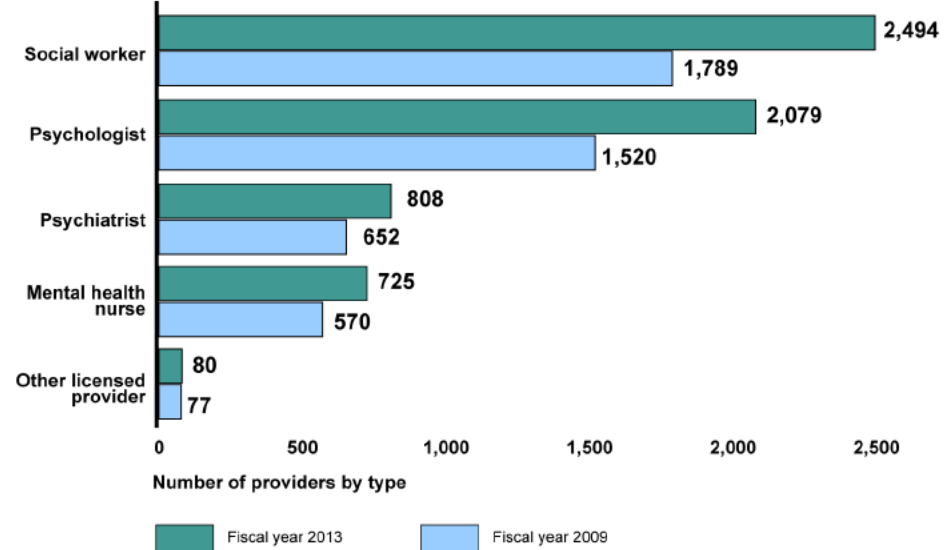
DEFENSE HEALTH CARE

Additional Information Needed about Mental Health Provider Staffing Needs

What GAO Found

In response to the enactment of the National Defense Authorization Act (NDAA) for Fiscal Year 2010, the Department of Defense (DOD) military health system (MHS) increased its mental health provider staffing level by 34 percent. Specifically, DOD increased the number of mental health providers across the MHS from 4,608 providers in fiscal year 2009 to 6,186 providers in fiscal year 2013. Social workers and psychologists were the most frequently added types of mental health providers during this period.

Total Department of Defense (DOD) Mental Health Providers by Provider Type, September 2009 Compared to September 2013



Source: GAO analysis of DOD data. | GAO-15-184

In 2007, DOD created the Psychological Health Risk-Adjusted Model for Staffing (PHRAMS) to assess the MHS's current and future mental health provider staffing needs and DOD annually revises this model. Fiscal year 2014 marked the first time the model was used by the three military services responsible for providing health care—the Army, Air Force, and Navy—for a common purpose, which was the development of DOD's fiscal year 2016 budget request for mental health services. However, GAO found that the military services either were not using PHRAMS as the main basis of their mental health provider staffing needs estimates or were supplementing PHRAMS results with other service-specific methods. The services reported making these adjustments because PHRAMS does not account for factors that are crucial to assess mental health provider staffing needs, such as mental health providers needed for deployments. As a result, the military services' estimates of mental health provider staffing needs may not consistently reflect the beneficiary demand for mental health providers across the military services, and the current version of PHRAMS may not fully capture the military services' needs.

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Abbreviations

DHA	Defense Health Agency
DOD	Department of Defense
HPSP	Health Professions Scholarship and Financial Assistance Program
MHS	military health system
MTF	military treatment facility
NCR	National Capital Region
NDAA	National Defense Authorization Act
OASD HA	Office of the Assistant Secretary of Defense for Health Affairs
PHRAMS	Psychological Health Risk-Adjusted Model for Staffing
USUHS	Uniformed Services University of the Health Sciences

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January 30, 2015

The Honorable Thad Cochran
Chairman
The Honorable Richard J. Durbin
Vice Chairman
Subcommittee on Defense
Committee on Appropriations
United States Senate

Mental health providers are essential to maintaining the Department of Defense's (DOD) capability to deliver health care services.¹ As part of its mission, DOD provides a full range of medical care and services, including mental health services, at no cost to active duty military servicemembers and at either a reduced cost or no cost to other eligible beneficiaries—including dependents of servicemembers and some military retirees.² DOD's ability to deliver this care has been impacted by increasing numbers of servicemembers who experienced life-threatening situations in combat and their resulting need for mental health services.³ Specifically, DOD faces significant challenges building and maintaining a mental health provider workforce—including active duty and reserve military providers and civilian and contract providers working in military medical facilities—that is capable of providing all the mental health care servicemembers and their dependents need due to nationwide shortages

¹See GAO, *Military Personnel: Enhanced Collaboration and Process Improvements Needed for Determining Military Treatment Facility Medical Personnel Requirements*, [GAO-10-696](#) (Washington, D.C.: July 29, 2010).

²Within DOD's health care system, servicemembers, dependents, and other beneficiaries can receive care both in DOD's own military treatment facilities (MTF) or through its TRICARE purchased care system of civilian providers. The TRICARE purchased care network is used to supplement the care provided by MTFs and MTFs may review all requests for specialty care, such as mental health care, to determine if they have the capability and capacity to provide the care.

³See Executive Order 13625, *Improving Access to Mental Health Services for Veterans, Service Members, and Military Families* (Aug. 31, 2012).

of mental health providers.⁴ These challenges are exacerbated by the pressure to control DOD healthcare costs and the need to compete for mental health providers with other health care delivery systems throughout the nation which also face increased needs for these providers.⁵

The increased need for mental health care for servicemembers and their dependents has led to congressional attention on the recruitment and retention of qualified mental health providers to work in DOD's military health system (MHS). Specifically, the National Defense Authorization Act (NDAA) for Fiscal Year 2010 included provisions for DOD to increase its mental health capabilities by increasing the number of active duty mental health providers and to report on the appropriate number of mental health providers required to meet the mental health care needs of servicemembers, retirees, and dependents.⁶

You asked us to review DOD's efforts to increase its qualified mental health provider workforce. In this report we examine (1) the staffing levels of DOD military, civilian, and contracted mental health providers and how these staffing levels have changed in response to the NDAA for Fiscal Year 2010; (2) how DOD and the military services assess current and future needs for mental health providers; and (3) how the military services report mental health provider staffing levels and future needs to DOD.

⁴In this report, we use the term mental health provider to describe a licensed or certified clinical provider—those that have met the minimum requirements needed to obtain and maintain a license or certification—including psychiatrists, psychologists, mental health nurse practitioners, mental health registered nurses, licensed social workers, and other licensed providers. We did not review other types of mental health personnel, such as administrative staff and technicians, who may not be licensed or certified but may be included in the population referred to by applicable laws. In this report we use the term mental health provider and mental health personnel interchangeably.

⁵See Congressional Budget Office, *Approaches to Reducing Federal Spending on Military Health Care: Actual and Projected Costs for Military Health Care as a Share of DOD's Base Budget, 2000 to 2028*, Pub. No. 4282 (January 2014).

⁶See Pub. L. No. 111-84, § 714, 123 Stat. 2190, 2381 (Oct. 28, 2009). The NDAA for Fiscal Year 2010 required DOD to increase the number of active duty mental health personnel. We discuss the status of these personnel increases in this report. The NDAA for Fiscal Year 2010 also required DOD to submit to Congress no later than one year after the enactment of the Act a report on the appropriate number of mental health personnel required to meet the mental health care needs of servicemembers, military retirees, and dependents. DOD issued this report to appropriate congressional committees in February 2011 and defined staffing levels for each service.

To examine the staffing levels of DOD military, civilian, and contract mental health providers and how these staffing levels changed in response to the NDAA for Fiscal Year 2010, we analyzed quarterly mental health staffing reports for fiscal years 2009 through 2013 submitted to DOD from each military service and the National Capital Region (NCR) Medical Directorate.⁷ We analyzed these reports separately and together to report current mental health provider staffing levels and compare mental health provider staffing levels from fiscal year 2009, prior to the enactment of the NDAA for Fiscal Year 2010, with such levels from fiscal year 2013. Fiscal year 2013 was the most recent fiscal year with complete data available for analysis. To ensure the reliability of these data, we interviewed Office of the Assistant Secretary of Defense for Health Affairs (OASD HA) officials responsible for collecting and analyzing these quarterly staffing reports and reviewed documentation related to the production of these reports. Based on these actions, we found information contained in these quarterly staffing reports to be sufficiently reliable for the purposes of this report.

To examine how DOD and the military services assess current and future needs for mental health providers, we interviewed officials from OASD HA, Army, Air Force, Navy,⁸ the DOD Task Force on Mental Health, and the Interagency Task Force on Military and Veterans Mental Health to learn about actions taken to assess mental health provider staffing

⁷NCR Medical Directorate manages DOD medical facilities within the national capital region. Military mental health providers working within NCR Medical Directorate facilities are accounted for in their military services' quarterly mental health staffing reports. However, the NCR Medical Directorate manages its own civilian and contract provider workforce and, as a result, reports its staffing levels separately from the military services for these two types of mental health providers.

⁸The Navy provides health care services for the Marine Corps.

levels.⁹ We also reviewed the Psychological Health Risk-Adjusted Model for Staffing (PHRAMS), DOD's mental health staffing model used to project the number and mix of health care providers needed to meet the mental health care needs of the DOD health care system—including procedure guides and year-end reports.

To examine how the military services report mental health provider staffing levels and future needs to DOD, we interviewed officials from OASD HA, Army, Air Force, Navy, and the NCR Medical Directorate to learn about their use of quarterly mental health staffing reports. We also reviewed the quarterly mental health staffing reports submitted by the military services and the NCR Medical Directorate for fiscal years 2009 through 2013.

We conducted this performance audit from May 2014 to January 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The MHS operated by DOD has two missions: (1) supporting wartime and other deployments and (2) providing peacetime health care.¹⁰ In support

⁹Section 723 of the NDAA for Fiscal Year 2006 directed the Secretary of Defense to establish a task force to examine Armed Forces mental health issues and produce a report containing an assessment of, and recommendations for, improving the efficacy of mental health services provided to servicemembers by DOD. The DOD Task Force on Mental Health was comprised of seven military and seven civilian professionals with mental health experience and issued its final report in June 2007. In August 2012, the President signed an executive order establishing an Interagency Task Force on Military and Veterans Mental Health, co-chaired by the Secretaries of Defense, Veterans Affairs, and Health and Human Services. This task force coordinates and reviews agency efforts to enhance veteran and military mental health and substance abuse services and develops recommendations on strategies to improve these services. See Executive Order 13625, *Improving Access to Mental Health Services for Veterans, Service Members, and Military Families* (August 31, 2012).

¹⁰See GAO, *Defense Health Care: Department of Defense Needs a Strategic Approach to Contracting for Health Care Professionals*, [GAO-13-322](#) (Washington, D.C.: May 28, 2013). According to DOD, the MHS mission is to provide optimal health services in support of our nation's military mission—anytime, anywhere.

of these two missions, DOD operates a large and complex health care system that employs more than 150,000 military, civilian, and contract personnel working in military medical facilities, commonly referred to as military treatment facilities (MTF).

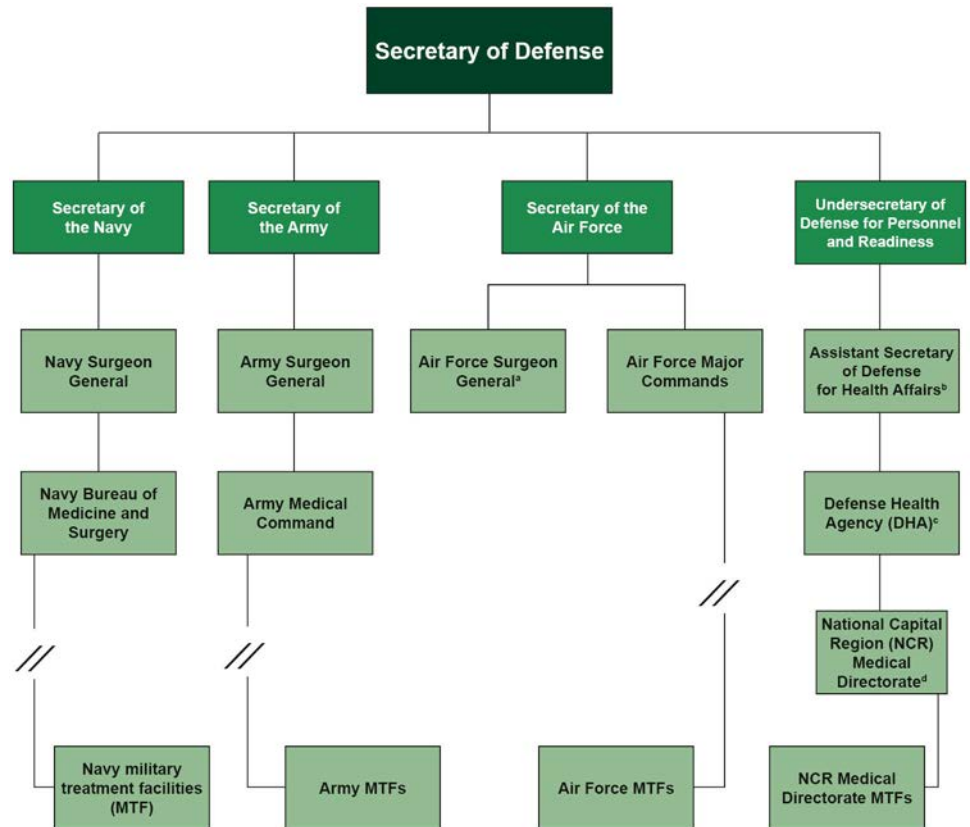
In terms of the MHS organization and structure, OASD HA serves as the principal advisor for all DOD health policies and programs. OASD HA has the authority to issue DOD instructions, publications, and memorandums that implement policy approved by the Secretary of Defense or the Under Secretary of Defense for Personnel and Readiness and govern the management of DOD medical programs. In October 2013, the Defense Health Agency (DHA) was established to support greater integration of clinical and business processes across the MHS. The DHA manages the execution of policies issued by OASD HA, oversees the TRICARE health plan, and also exercises authority and control over the MTFs and subordinate clinics assigned to the NCR Medical Directorate.¹¹

MTFs and their subordinate clinics are operated by either a military service or the NCR Medical Directorate. Neither OASD HA nor DHA have direct command and control of MTFs operated solely by the military services.¹² Each military service recruits, trains, and funds its own medical personnel to administer medical programs and provide medical services to beneficiaries. The NCR Medical Directorate has direct authority over civilian providers and personnel working within its facilities; however, the military services maintain authority over all military providers and personnel working within NCR Medical Directorate MTFs. See figure 1 for the current organizational and governance structure of the MHS.

¹¹In addition to operating its own health care facilities, DOD also provides health care to military servicemembers, dependents, and military retirees through its TRICARE purchased care network. TRICARE supplements the health care resources of DOD with networks of civilian health care providers.

¹²The Army and Navy each have a medical command, headed by a surgeon general, who manages each department's MTFs and other activities through a regional command structure. The Navy provides medical services for both Navy and Marine Corps installations. Unlike the Surgeons General for the Army and Navy, the Air Force Surgeon General exercises no command authority over Air Force MTFs; instead, Air Force MTF commanders report to local line commanders.

Figure 1: Governance Structure of the Department of Defense (DOD) Military Health System (MHS)



Source: GAO. | GAO-15-184

^aThe Air Force Surgeon General does not have direct authority over Air Force MTFs; however, the Air Force Surgeon General exercises similar authority to that of the other Surgeons General through his role as medical advisor to the Air Force Chief of Staff.

^bThe Assistant Secretary of Defense for Health Affairs is the principal advisor for all DOD health policies and programs. The Office of the Assistant Secretary of Defense for Health Affairs (OASD HA) also has the authority to issue DOD instructions, publications, and memorandums that implement policy approved by the Secretary of Defense or the Under Secretary of Defense for Personnel and Readiness.

^cDHA was established to support greater integration of clinical and business processes across the MHS. DHA manages the execution of policies issued by OASD HA, oversees the TRICARE health plan, and also exercises authority and control over the MTFs and subordinate clinics assigned to the NCR Medical Directorate.

^dThe NCR Medical Directorate was initially established as a DOD joint task force in September 2007 to operate DOD's medical facilities in the national capital region—including Walter Reed National Military Medical Center, Fort Belvoir Community Hospital, and their supporting clinics. The NCR Medical Directorate reassigned civilian personnel from the military services to the NCR Medical Directorate, while retaining military health care providers within the appropriate military service's command and control.

DOD and the Military Services Have Increased the Number of Mental Health Providers to About 6,200—an Increase of Over a Third between Fiscal Years 2009 and 2013

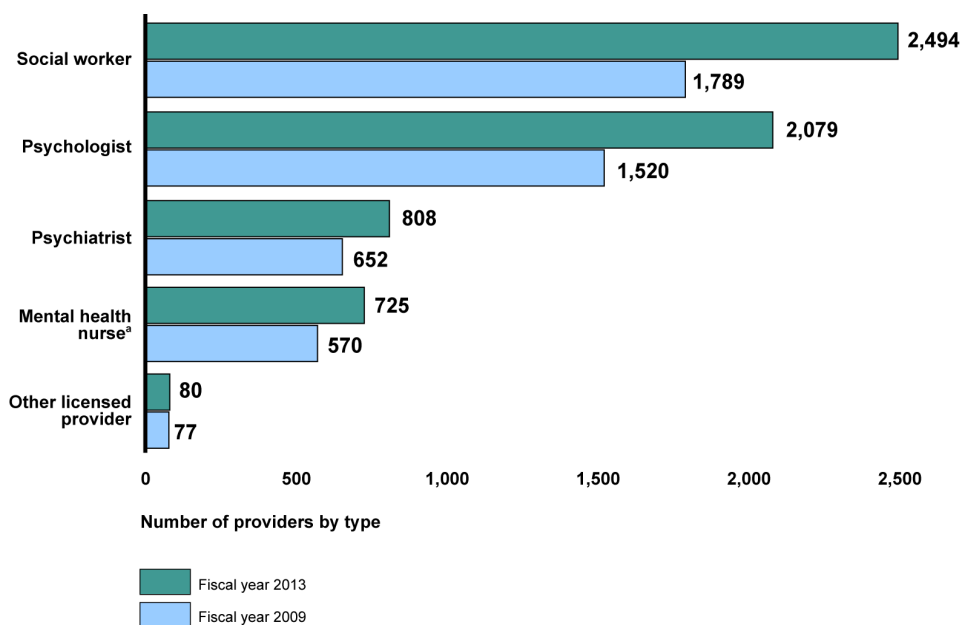
The MHS has increased its overall mental health provider staffing level by 34 percent between fiscal years 2009 and 2013. Specifically, DOD increased the number of providers across the MHS from 4,608 providers in fiscal year 2009 to 6,186 providers in fiscal year 2013.¹³ (See app. I for more information on fiscal year 2013 mental health provider staffing.) This increase was in response to a requirement in the NDAA for Fiscal Year 2010 that DOD increase its mental health capabilities.¹⁴ (See app. II for more information on the recruitment and retention of DOD mental health providers.)

The type of mental health providers added to the MHS from fiscal year 2009 to fiscal year 2013 varied. (See fig. 2.) Specifically, social workers and psychologists were the most frequently added types of mental health providers during this period, while psychiatrists and mental health nurses were the least frequently added. The Army drove the overall increase in social workers and psychologists by adding 496 of the 705 social workers and 421 of the 559 psychologists to the MHS during this period. The Air Force added more social workers (64) than any other type of provider during this period, while the Navy added more psychologists (32) and other licensed providers (32). (See app. III for additional information on the breakdown of mental health provider staffing level changes for each military service from fiscal year 2009 to fiscal year 2013.)

¹³Mental health provider totals in this report have been rounded to the nearest full-time equivalent. Information on mental health provider staffing levels contained in this report was obtained from quarterly mental health staffing reports submitted by the military services to DHA through the OASD HA human capital office.

¹⁴See Pub. L. No. 111-84, § 714, 123 Stat. 2190, 2381 (Oct. 28, 2009).

Figure 2: Total Department of Defense (DOD) Mental Health Providers by Provider Type, September 2009 Compared to September 2013



Source: GAO analysis of DOD data. | GAO-15-184

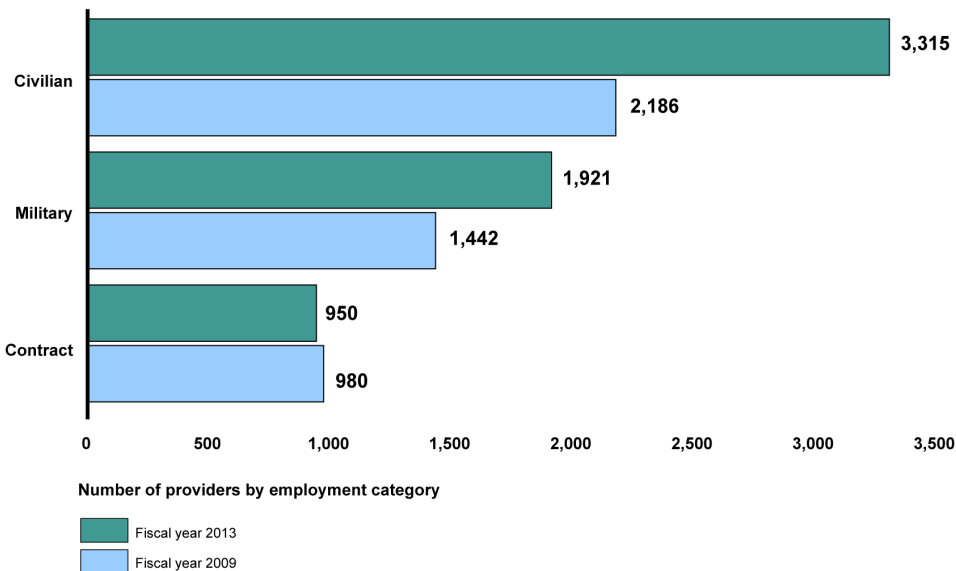
Notes: The total number of DOD mental health providers in fiscal year 2013 was 6,186. The total number of DOD mental health providers in fiscal year 2009 was 4,608. Mental health provider totals in this figure have been rounded to the nearest full-time equivalent.

^aThe mental health nurse category includes both mental health nurse practitioners and mental health registered nurses. In fiscal year 2009, DOD did not report separate employment information on these two types of mental health providers.

During this time frame, the composition of DOD mental health provider staff by employment category also changed. Across the MHS, the number of civilian mental health providers increased by 52 percent (1,129) and military mental health providers increased by 33 percent (479), while the number of contract mental health providers decreased by 3 percent (30). (See fig. 3.) The services' individual changes varied, with the Army driving this systemic shift to civilian providers. Specifically, the Army added 863 new civilian mental health providers (a 50 percent increase), while decreasing the number of contract mental health providers by 153 (a 33 percent decrease). The Air Force also increased its civilian mental health provider staffing by 5 providers (a 2 percent increase) and increased its contract mental health provider staffing by 72 providers (a 39 percent increase). The Navy increased its number of military mental health providers by 113 (a 38 percent increase), added 12 civilian mental

health providers (a 5 percent increase), and decreased contract mental health providers by 37 (an 11 percent decrease).

Figure 3: Total Department of Defense (DOD) Mental Health Providers by Employment Category, September 2009 Compared to September 2013

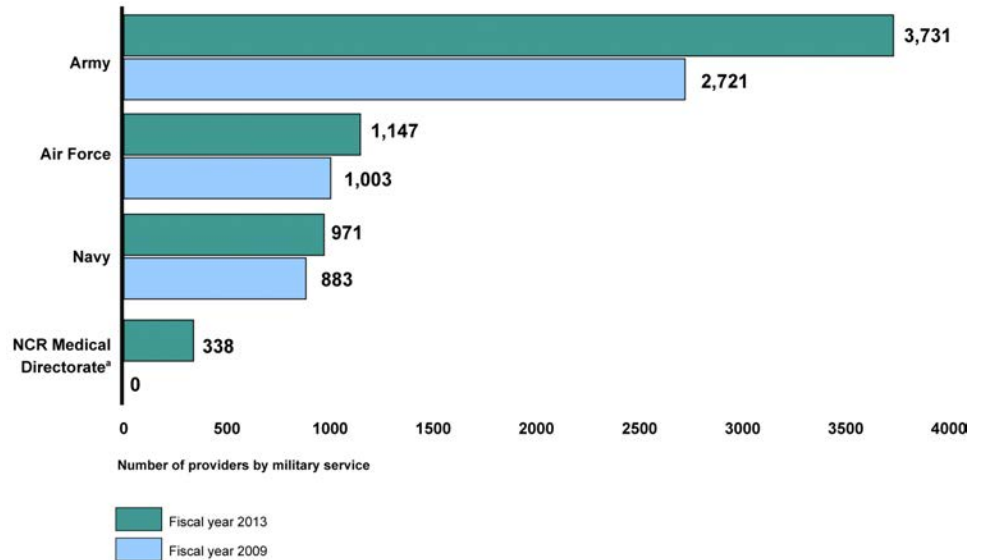


Source: GAO analysis of DOD data. | GAO-15-184

Notes: The total number of DOD mental health providers for fiscal year 2013 was 6,186. The total number of DOD mental health providers for fiscal year 2009 was 4,608. Mental health provider totals in this figure have been rounded to the nearest full-time equivalent.

While all three military services increased their mental health provider staffing from fiscal year 2009 to fiscal year 2013, the Army's addition of 1,010 mental health providers represented the largest portion of the DOD-wide increase. The Navy's increase of 88 mental health providers was the smallest portion of the DOD-wide increase. (See fig. 4.)

Figure 4: Total Department of Defense (DOD) Mental Health Providers by Military Service and the National Capital Region (NCR) Medical Directorate, September 2009 Compared to September 2013



Source: GAO analysis of DOD data. | GAO-15-184

Notes: The total number of DOD mental health providers in fiscal year 2013 was 6,186. The total number of DOD mental health providers in fiscal year 2009 was 4,608. Mental health provider totals in this figure have been rounded to the nearest full-time equivalent.

^aIn fiscal year 2009, all civilian and contract mental health providers assigned to the military treatment facilities (MTF) and subordinate clinics that are now within the NCR Medical Directorate were included in the military service totals, because at that time all MTFs within the NCR Medical Directorate were managed by multiple military services. In fiscal year 2013, the NCR Medical Directorate reported its own civilian and contract mental health provider totals while retaining military mental health providers within the appropriate military services' figures.

DOD Created a Model for Developing Mental Health Provider Staffing Needs, but the Military Services Do Not Use It Consistently

DOD created the Psychological Health Risk-Adjusted Model for Staffing (PHRAMS) to show current and estimate future mental health provider staffing needs of the MHS. In fiscal year 2014, PHRAMS was used for a common purpose by the military services for the first time—the development of the fiscal year 2016 DOD budget request for mental health programs.¹⁵ However, the military services are either not using PHRAMS as the primary basis of their estimates of mental health provider staffing needs or supplementing their PHRAMS results with service-specific staffing methods. This limits DOD's ability to consistently assess mental health provider staffing needs throughout the MHS.

DOD Created PHRAMS to Estimate Its Current and Future Mental Health Provider Staffing Needs

PHRAMS projects the number and mix of providers needed to meet the mental health care needs of the MHS. In fiscal year 2007, DOD contracted with a non-profit research and analysis organization to develop PHRAMS in response to recommendations from the DOD Task Force on Mental Health.¹⁶ These recommendations included that: (1) Congress fund and DOD allocate sufficient staff to provide a full continuum of mental health services to servicemembers and their dependents and (2) DOD adopt a risk-adjusted population-based model to calculate mental health staffing needs. As of September 2014, the contract to develop and maintain PHRAMS had cost DOD \$2 million, according to DOD officials.

PHRAMS is designed to be a common DOD-wide model that can be used by the military services to assess current mental health provider staffing

¹⁵This was in response to a September 2013 memorandum from the Assistant Secretary of Defense for Health Affairs that requested that the military services nominate their choice of a mental health provider staffing model that would meet the following three criteria: (1) demonstrate adaptability to the Army, the Air Force, and the Navy; (2) demonstrate clinical validity to be used for the budget request to predict staffing; and (3) be ready for use for the fiscal year 2016 budget request. PHRAMS was the selected model for this process, which began in fiscal year 2014.

¹⁶DOD contracted with the CNA Corporation for the development and maintenance of PHRAMS.

needs and forecast these staffing needs over a 5-year timeframe.¹⁷ DOD intended PHRAMS to allow the Department to fulfill two goals: (1) assess whether or not there are enough mental health providers within the MHS to meet the increased mental health needs of servicemembers and their dependents that resulted from their experiences in recent conflicts, and (2) allow the Department to report the mental health provider staffing needs of the MHS to Congress. DHA and the PHRAMS contractor engage in an annual model review process to incorporate changes requested by the military services into the next version of the model. According to DHA officials, PHRAMS was used for a common purpose for the first time in fiscal year 2014—the development of the DOD fiscal year 2016 budget request for mental health programs.

To assess current mental health provider staffing needs and determine 5-year forecasts of these needs, PHRAMS places MHS beneficiaries—including servicemembers, dependents, and other beneficiaries—into 40,500 individual risk groups based on unique combinations of eight risk factors.¹⁸ (See fig. 5.)

¹⁷In addition to mental health providers, PHRAMS also includes estimates for the number of full-time equivalent primary care and other providers, including chaplains, needed by the MHS to administer mental health services. Primary care and other provider estimates are generated by PHRAMS because these providers deliver some mental health services to MHS beneficiaries.

¹⁸Some risk factors for dependents of servicemembers are populated based on their sponsoring servicemember's information.

Figure 5: Risk Factors Included in the Department of Defense (DOD) Psychological Health Risk-Adjusted Model for Staffing (PHRAMS)



Source: GAO analysis of DOD documents. | GAO-15-184

Notes: This figure includes all risk factors included in version 5 of PHRAMS.

^aDeployment experience is a combination of how recently servicemembers have been deployed and the degree of their deployments. PHRAMS considers servicemembers to be recently deployed if they deployed within the past year. The degree of deployment is a combination of the number of deployments and the cumulative number of months a servicemember has been deployed between September 2001 and the end of fiscal year 2012. Servicemembers will have high degrees of deployment if one of two conditions occur: (1) they have been cumulatively deployed for 12 months or more or (2) they have been cumulatively deployed for 6 to 12 months with fewer than 3 deployments. Servicemembers have moderate degrees of deployment if they have ever deployed and do not meet the criteria for a high degree of deployment.

^bRank groups are divided into junior and senior categories. For enlisted servicemembers, the first four ranks in each military service are considered junior and the next five ranks are considered senior. For officers, the first three ranks in each military service are considered junior and the next seven ranks are considered senior. Warrant Officers are categorized as senior enlisted.

^cA small percentage of the beneficiary population has missing information for one or more risk factor data elements. PHRAMS assigns these individuals to an “unknown” group.

^dRisk factor values for component, service, deployment experience, and rank group for family members are populated using the sponsoring servicemember's information.

^eIn addition to operating its own health care facilities, DOD also provides health care to servicemembers, dependents, and military retirees through its TRICARE purchased care network. TRICARE supplements the health care resources of DOD with networks of civilian health care providers.

To determine MTF-based mental health provider staffing needs,¹⁹ PHRAMS calculates three key aspects of mental health services in the MHS—(1) the beneficiary demand for mental health services; (2) the number of appointments needed to treat these conditions, referred to as encounters; and (3) the availability of MHS mental health providers to supply these encounters. (See fig. 6.)

- **Beneficiary demand for mental health services.** PHRAMS uses historical data to determine the prevalence of certain mental health diagnoses within each of the 40,500 risk groups included in the model.²⁰ These prevalence rates are then combined with projections of the number of beneficiaries in each risk group to estimate the

¹⁹See L.M. Pikulin and D.M. Harris, *The Psychological Health Risk-Adjusted Model for Staffing (PHRAMS): Update for Version 5.0*, a special report prepared at the request of the Department of Defense, December 2013. PHRAMS is also used to estimate the number of TRICARE providers that will be needed to provide mental health services to beneficiaries enrolled in the TRICARE network.

²⁰PHRAMS uses a number of mental health diagnoses in its calculations, including those in the following groups: (1) psychoses, (2) non-psychotic depressive disorders, (3) anxiety-related disorders, (4) neurotic disorders, (5) post-traumatic stress disorder, (6) adjustment reaction disorders (excluding post-traumatic stress disorder), (7) acute reaction to stress, (8) substance-induced mental disorders, (9) substance dependence, (10) non-dependent substance abuse, (11) psychotic disorders of childhood, (12) non-psychotic disorders of childhood, (13) schizophrenic disorder, (14) personality disorders, (15) disturbance of conduct not elsewhere classified, (16) other psychotic disorders, and (17) other non-psychotic disorders. PHRAMS also estimates the prevalence of a number of mental health related events, such as (1) personal or family history of mental or psychiatric diagnosis, (2) mental or behavioral problem influencing health status, (3) specific mental health circumstances, (4) mental health examination and observation with no reported diagnosis, (5) mental health condition in a mother complicating pregnancy, (6) post-deployment health assessments and post-deployment health reassessments, and (7) other cases where the diagnosing provider is a mental health provider.

demand for mental health services each risk group will place on the MHS.²¹

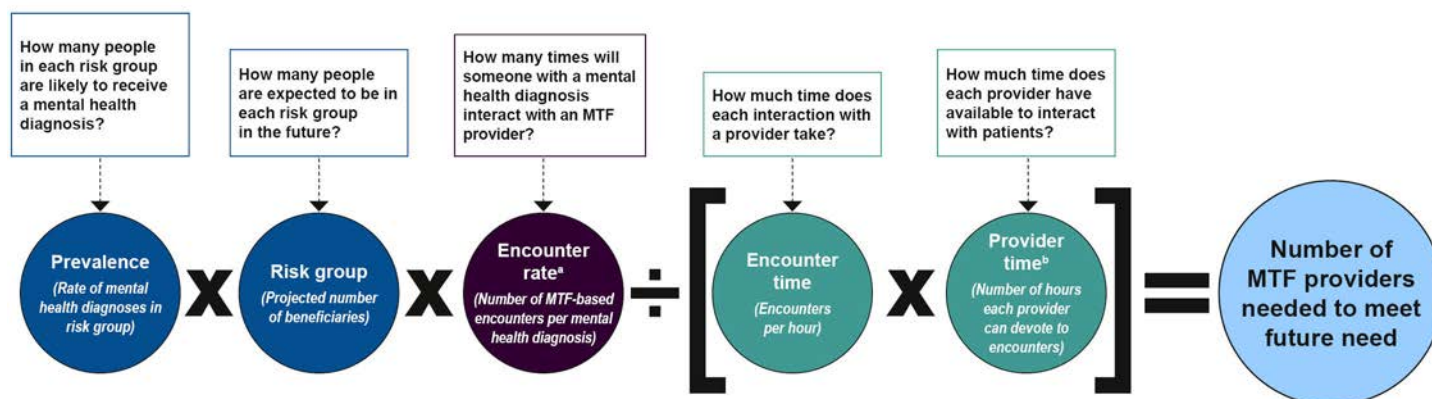
- **Number of appointments (encounter rate).** PHRAMS calculates the number of appointments that will be needed to treat diagnosed beneficiaries within each risk group. To do this, the model applies predetermined encounter rates that specify how many times a beneficiary with each mental health diagnosis included in the model will interact with an MTF provider.²²
- **Availability of MHS mental health providers.** PHRAMS then determines the number of encounters each MTF-based mental health provider can supply each year by multiplying the number of encounters that can be completed each hour (encounter time) by the total number of annual hours each mental health provider can spend supplying mental health services to beneficiaries (provider time).²³

²¹The model includes a small upward adjustment to each risk group's prevalence rate to account for untreated mental health conditions in the beneficiary population.

²²To establish the encounter rates used in PHRAMS, the PHRAMS contractor created a composite encounter rate for each mental health condition included in the model based on five inputs: (1) recommendations from a Navy work group, (2) recommendations from an Air Force work group, (3) information gathered from reviews of clinical literature, (4) information gathered from reviews of clinical practice guidelines, and (5) other interviews. Encounter rates are also adjusted based on historical data.

²³Military and civilian mental health providers have different amounts of hours they can devote to encounters each year. For example, the default value in PHRAMS version 5 for military mental health providers' clinical encounter time was set at 1,190 hours per year, while the default value for civilian mental health providers' clinical encounter time was set at 1,399. This difference accounts for the hours military mental health providers spend each year performing military-specific duties not related to beneficiary care and differences in assumed productivity for military and civilian mental health care providers.

Figure 6: Department of Defense (DOD) Psychological Health Risk-Adjusted Model for Staffing (PHRAMS) Military Treatment Facility (MTF)-Based Mental Health Provider Needs Calculation



Source: GAO analysis of DOD documents. | GAO-15-184

Notes: This figure includes information from version 5 of PHRAMS. PHRAMS is also used to estimate the number of TRICARE providers that will be needed to provide mental health services to beneficiaries enrolled in the TRICARE network.

^aTo establish the encounter rates used in PHRAMS, the PHRAMS contractor created a composite encounter rate for each mental health condition included in the model based on five inputs: (1) recommendations from a Navy work group, (2) recommendations from an Air Force work group, (3) information gathered from reviews of clinical literature, (4) information gathered from reviews of clinical practice guidelines, and (5) other interviews. Encounter rates are also adjusted based on historical data. PHRAMS assigns all predicted encounters to either MTFs or the TRICARE network. Within the model, military service users can modify the percentage of encounters that are assigned to MTFs and the TRICARE network.

^bMilitary and civilian mental health providers have different amounts of hours they can devote to encounters each year. For example, the default value in PHRAMS version 5 for military mental health providers' clinical encounter time was set at 1,190 hours per year, while the default value for civilian mental health providers' clinical encounter time was set at 1,399. This difference accounts for the hours military mental health providers spend each year performing military-specific duties not related to beneficiary care and differences in assumed productivity for military and civilian mental health care providers.

Military Services Mental Health Provider Estimates Are Not Based Mainly on PHRAMS

Despite all military services agreeing to use PHRAMS to generate their estimates of mental health provider staffing needs for the fiscal year 2016 budget request, the military services either did not use PHRAMS as the main basis for their mental health provider staffing estimates or supplemented PHRAMS results using other service-specific methods prior to submitting their fiscal year 2016 budget requests.²⁴ Standards for

²⁴While the NCR Medical Directorate was required to use PHRAMS for its fiscal year 2016 budget request, we focused our analysis in this section on only the military services.

internal control in the federal government state that agencies' control activities should ensure that management's directives are carried out.²⁵ The military services reported making these adjustments because PHRAMS does not account for several factors that are crucial to their assessment of mental health provider staffing needs, specifically the following:

- **Army.** Army officials reported that they did not use PHRAMS as the basis for their fiscal year 2016 budget request and instead determined their mental health provider staffing needs through their legacy staffing model and adjusted PHRAMS to ensure it produced similar results. Unlike PHRAMS, which bases its mental health provider staffing estimates on beneficiary demand for services, the Army legacy staffing model uses historical workload data to estimate future staffing needs in multiple specialties, including mental health.²⁶ The Army legacy staffing model uses projected beneficiary population changes to adjust the historical workload for Army MTFs up or down as needed. According to the Army official responsible for generating manpower estimates for Army MTFs, PHRAMS does not currently meet the needs of the Army. This is because PHRAMS' assumption that all military services experience the same encounter rates for mental health conditions included in the model is an overgeneralization of mental health service demands. This official believes that this is particularly problematic for the Army because deployments are more traumatic for Army servicemembers and may result in some servicemembers requiring more than the average number of encounters. As a result, the Army only ran PHRAMS after the military service had already determined its mental health provider staffing needs through its legacy staffing model.
- **Air Force.** According to Air Force officials, while the Air Force uses some aspects of PHRAMS, it did not rely exclusively on PHRAMS to generate their estimates of mental health staffing needs included in the fiscal year 2016 budget request. These officials explained that

²⁵See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

²⁶The Army legacy staffing model calculates mental health provider staffing needs for each Army MTF by determining the number of relative value units for each MTF and projects the number of providers that are necessary to produce the desired level of productivity for the following year. Relative value units measure the amount of time and effort it takes to treat a beneficiary.

PHRAMS was the first step in a three-step process used to generate the Air Force's fiscal year 2016 budget request for mental health provider staffing. First, Air Force manpower staff ran PHRAMS and provided the PHRAMS-generated mental health provider staffing estimates to Air Force's mental health consultants for consideration.²⁷ Second, the Air Force mental health consultants developed multiple staffing level proposals by combining the PHRAMS output with their own expertise and information received during conversations with Air Force MTF officials. Finally, the Chief of Clinical Operations for the Air Force Medical Support Agency selected the best staffing proposal among those submitted for review by the Air Force mental health consultants. Air Force officials reported that this process was applied because PHRAMS relies on data that is several years old and does not take into account all aspects of Air Force mental health provider staffing, such as mental health providers embedded in operational units. Air Force officials also explained that they plan to continue using this process in the future to generate mental health provider staffing estimates.

- **Navy.** Navy officials reported that they used PHRAMS, but supplemented PHRAMS estimates of mental health provider staffing needs with additional information. According to Navy officials, this was necessary because PHRAMS does not include estimates of mental health provider staffing needs on Navy vessels and for deployed Marine Corps units. As a result, Navy officials adjusted their PHRAMS output to account for these additional needs for mental health providers. These officials explained that they relied on traditional methods—such as on-site industrial engineering reviews and industry standards—to calculate these operational requirements for Navy mental health providers. According to Navy officials, the fiscal year 2016 budget request submitted by the Navy for mental health provider staffing is the sum of the estimated staffing levels generated by PHRAMS and the calculated operational requirements for mental health providers.

When we shared this information with DHA officials, they told us that they were unaware of specific supplemental or alternative methods used by the military services to determine their final mental health provider staffing

²⁷ An Air Force official told us that Air Force mental health consultants are senior clinicians from a variety of specialties assigned as consultants to the Air Force Surgeon General to assist in staffing and other necessary operations.

estimates. However, these officials did note that the military services do make modifications to their PHRAMS results through modifying certain aspects of the model and DHA does not collect information on these modifications. DHA and the PHRAMS contractor review the model annually to incorporate changes requested by the military services in the next version of the model. Standards for internal control in the federal government state that information should be recorded and communicated to management and others within the agency that need it in a format and time frame that enables them to carry out their responsibilities.²⁸ However, since DHA did not have access to this information on how the military services supplemented PHRAMS for their fiscal year 2016 budget request, this critical information was not included in this annual update process.

As a result of the military services' alterations to PHRAMS estimates of mental health provider staffing needs, DHA cannot consistently determine how beneficiary demand affects the mental health provider staffing needs for the MHS. Specifically, due to the Army's use of a workload-based staffing estimate, the resulting mental health provider staffing needs estimates submitted for the fiscal year 2016 budget process may not consistently reflect the beneficiary demand for mental health services across military services. In addition, without an accurate picture of the ways the military services altered or supplemented PHRAMS results, DHA cannot evaluate the role PHRAMS played in the development of the fiscal year 2016 budget request for mental health provider staffing and cannot ensure that it is directing the PHRAMS contractor to make the most appropriate changes to the model that minimize the need for these service-specific supplements.

²⁸ [GAO/AIMD-00-21.3.1.](#)

Military Services Report Mental Health Provider Staffing Levels on Quarterly Reports Submitted to DHA, But Do Not Report Reliable Information on Future Needs

The military services submit quarterly reports to DHA through the OASD HA human capital office that include information on their current mental health provider staffing levels and should, as requested, include information on their future needs for these providers. However, the military services do not include reliable information about their mental health provider staffing needs on these quarterly reports, despite having access to PHRAMS since fiscal year 2010.²⁹ As a result, DHA does not have an accurate picture of the mental health provider staffing needs of the MHS and cannot accurately report this information to Congress. Standards for internal control in the federal government state that information should be recorded and communicated to management and others within the agency that need it in a format and time frame that enables them to carry out their responsibilities.³⁰

DHA requests information each quarter from the military services and the NCR Medical Directorate on mental health provider staffing in order to understand the MHS-wide use and need for these providers and report this information to Congress when requested. Each military service and the NCR Medical Directorate submits quarterly staffing reports to DHA through the OASD HA human capital office that include information on three areas of mental health provider staffing: (1) the number of mental health providers each military service needs to fulfill the needs of their beneficiaries, referred to as requirements; (2) the number of authorized positions each military service has for various types of mental health providers, referred to as authorizations; and (3) the actual number of mental health providers each military service has working within their MTFs and subordinate clinics that quarter, referred to as on-board providers. However, we found that information reported is unreliable. Specifically, we found the following:

- According to DHA officials, only the Army submits information on the number of mental health providers its MTFs and subordinate clinics need to serve Army beneficiaries and it derives these numbers from the Army workload-based legacy staffing model.
- DHA officials told us that the Navy and the Air Force do not track needs for mental health provider staffing. Instead, they submit the

²⁹DOD refers to staffing needs as requirements.

³⁰See [GAO/AIMD-00-21.3.1](#).

number of authorized mental health provider positions for both the requirements and authorizations sections of these quarterly reports. NCR Medical Directorate officials told us that the requirements section of their quarterly reports are populated using the staffing needs identified in the intermediate manpower planning documents that were created during the formation of the NCR Medical Directorate. According to DOD officials, the NCR Medical Directorate is currently reviewing the staffing needs of its MTFs and subordinate clinics and anticipates completion of this review by December 2014.

Without reliable information from the military services and the NCR Medical Directorate on the quarterly reports, DHA cannot assess the need for mental health providers throughout the MHS and cannot ensure that it is providing assistance to the military services in meeting their unmet needs. The military services have had access to PHRAMS since fiscal year 2010 and the model could be used to assess the mental health provider needs of each military service and the NCR Medical Directorate on an ongoing basis. Incorporating this information into the requirements section of the quarterly reports each military service and the NCR Medical Directorate submit to DHA through the OASD HA human capital office would provide this important information to DHA. In addition, this information would also ensure greater consistency in the military services' and the NCR Medical Directorate's assessment of this aspect of mental health provider staffing and ensure greater accuracy in DOD's reports to Congress about mental health provider staffing.

Conclusions

While PHRAMS has been in development since fiscal year 2007, the military services only recently began using the model for a common purpose—the fiscal year 2016 DOD budget request. However, PHRAMS is not meeting its intended goals because the military services are not using it consistently to assess their mental health provider staffing needs. Instead, the military services are supplementing PHRAMS mental health provider staffing estimates with additional information. It is critical that the military services report how they have supplemented PHRAMS to ensure (1) that DHA and the PHRAMS contractor can correctly analyze and interpret the military services' mental health provider staffing estimates, and (2) that PHRAMS is updated regularly to meet the needs of the military services. DHA is also unable to generate accurate reports to Congress on the staffing needs of the entire MHS, because the military services are not using PHRAMS to generate consistent mental health provider staffing needs estimates and are instead reporting unreliable

estimates on their quarterly reports. DHA is therefore unable to assess and report on current mental health provider staffing needs.

Recommendations for Executive Action

To ensure DHA can accurately and consistently assess mental health provider staffing needs across each of the military services, we recommend that the Secretary of Defense direct the Secretaries of the Army, Air Force, and Navy to take the following two actions:

- Require the medical commands of each military service to report any additional service-specific methods they use to determine their final estimates of mental health provider staffing needs; and
- Require the medical commands of each military service to include its estimated mental health provider staffing needs generated through PHRAMS in the requirements fields of DHA's quarterly mental health staffing reports.

We further recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to take the following two actions:

- Ensure DHA, through the PHRAMS contractor, continue to refine PHRAMS to incorporate the needs of the military services to reduce the need for additional service-specific methods of determining mental health provider staffing needs; and
- Require the NCR Medical Directorate to include its estimated mental health provider staffing needs generated through PHRAMS in the requirements fields of DHA's quarterly mental health staffing reports.

Agency Comments and Our Evaluation

DOD provided comments on a draft of this report, which we have reprinted in appendix IV. In its comments, DOD generally concurred with two of our four recommendations. DOD also provided technical comments, which we have incorporated as appropriate.

DOD concurred with our recommendation that the Secretary of Defense should direct the Secretaries of the Army, the Air Force, and the Navy to require the medical commands of each military service to report any additional service-specific methods they use to determine their final estimates of mental health provider staffing needs. DOD did not provide a time frame or action plan for implementing this recommendation.

In addition, in response to our recommendation that the Secretary of Defense ensure DHA, through the PHRAMS contractor, continue to refine PHRAMS to incorporate the needs of military services to reduce the need for additional service-specific methods of determining mental health provider staffing needs, DOD said that DHA continues to serve in an advisory role to the military services to ensure that the next version of PHRAMS meets each service's needs. DOD did not provide a time frame or action plan for implementing this recommendation.

DOD did not concur with our recommendations to require the medical commands of each military service and the NCR Medical Directorate to include their estimated mental health provider staffing needs generated through PHRAMS in the requirements field of DHA's quarterly mental health staffing reports. DOD stated in its comments that using PHRAMS in the requirements fields of these reports will not add value to the quarterly mental health staffing reports and noted that the military services do not use PHRAMS as the sole source of mental health requirements. We disagree with DOD's conclusion and maintain that our recommendations should be implemented. The military services and the NCR Medical Directorate are not currently providing DHA with consistent information that it can rely on to: (1) make informed decisions regarding the MHS-wide usage and need for mental health providers and (2) develop reports to Congress based on this information.

Specifically, only one military service—the Army—reports the number of mental health providers that its MTFs need to serve Army beneficiaries in the requirements field of DHA's quarterly mental health staffing reports. The other two military services—the Air Force and the Navy—enter the number of mental health providers that were authorized by DOD for that fiscal year in the requirements field because they do not track mental health provider staffing needs. Additionally, the NCR Medical Directorate told us that it populates the requirements field of DHA's quarterly mental health staffing reports with information that was created during the formation of the NCR Medical Directorate several years ago and not with the current needs of its beneficiary population. We believe that to adequately assess the need for mental health providers throughout the MHS, DHA needs to have access to consistent and reliable information on mental health provider staffing needs in the quarterly mental health staffing reports. By not supplying consistent information on mental health provider staffing needs generated through PHRAMS—a common staffing model all military services and the NCR Medical Directorate have access to—the military services and the NCR Medical Directorate make it difficult to properly assess relative mental health provider staffing needs across

the services. If our recommendations were implemented, DHA would have access to consistent information about mental health provider staffing needs throughout the MHS and would be able to more reliably report this information to Congress.

We are sending copies of this report to the Secretary of Defense, appropriate congressional committees, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix V.



Randall B. Williamson
Director, Health Care

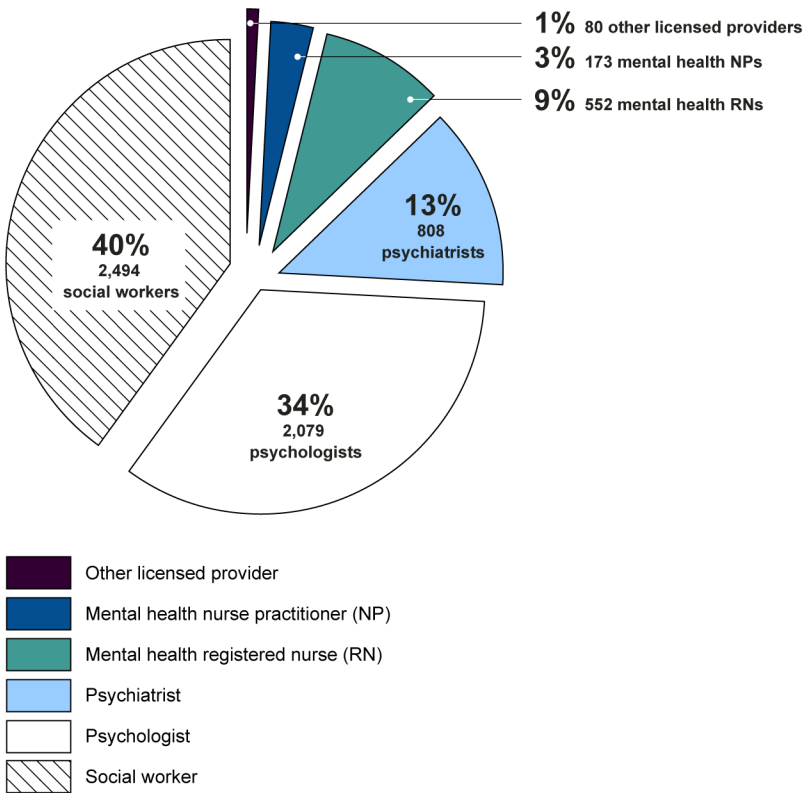
Appendix I: Fiscal Year 2013 Department of Defense Mental Health Provider Staffing

This appendix provides results from our analysis of Department of Defense (DOD) fiscal year 2013 quarterly mental health staffing reports. Each military service and the National Capital Region (NCR) Medical Directorate submit these reports to the Defense Health Agency (DHA) through the Office of the Assistant Secretary of Defense for Health Affairs (OASD HA) human capital office each quarter to identify their mental health staffing levels and needs.

- Figure 7 shows the total number of mental health providers working within the MHS by provider type as of September 2013.
- Figure 8 shows the total number of mental health providers working within the MHS by employment category as of September 2013.¹
- Figure 9 shows the total number of mental health providers working within the MHS by military service and the NCR Medical Directorate as of September 2013.
- Table 1 shows the mental health provider staffing levels for the Army as of September 2013.
- Table 2 shows the mental health provider staffing levels for the Air Force as of September 2013.
- Table 3 shows the mental health provider staffing levels for the Navy as of September 2013.
- Table 4 shows the mental health provider staffing levels for the NCR Medical Directorate as of September 2013.

¹Mental health providers working within the MHS fall within three employment categories: (1) military providers, who can be either active duty or reserve servicemembers; (2) civilian providers; or (3) contract providers.

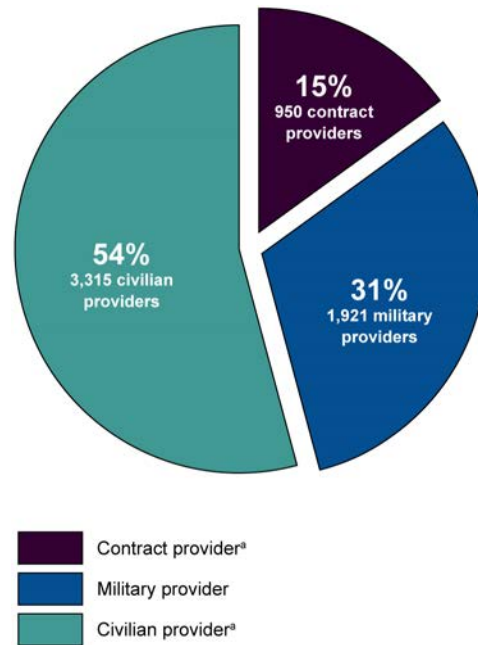
Figure 7: Total Department of Defense (DOD) Mental Health Providers by Provider Type, September 2013



Source: GAO analysis of DOD data. | GAO-15-184

Note: The total number of DOD mental health providers in fiscal year 2013 was 6,186. Mental health provider totals and percentages in this figure have been rounded to the nearest full-time equivalent.

**Figure 8: Total Department of Defense (DOD) Mental Health Providers by
Employment Category, September 2013**

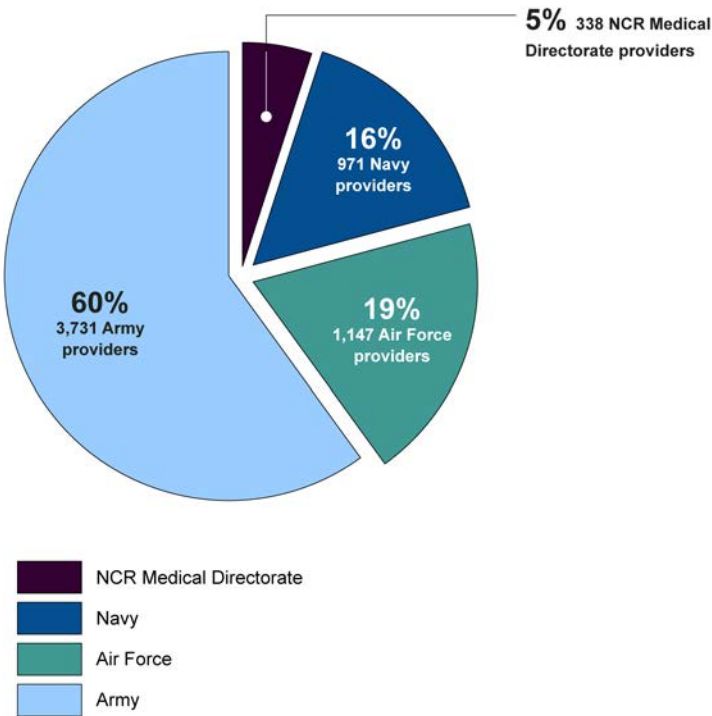


Source: GAO analysis of DOD data. | GAO-15-184

Note: The total number of DOD mental health providers in fiscal year 2013 was 6,186. Mental health provider totals and percentages in this figure have been rounded to the nearest full-time equivalent.

^aCivilian and contract providers are represented as full-time employee equivalent positions.

Figure 9: Total Department of Defense (DOD) Mental Health Providers by Military Service and the National Capital Region (NCR) Medical Directorate, September 2013



Source: GAO analysis of DOD data. | GAO-15-184

Note: The total number of DOD mental health providers in fiscal year 2013 was 6,186. Mental health provider totals and percentages in this figure have been rounded to the nearest full-time equivalent.

Table 1: Total Number of Army Mental Health Providers as of September 2013

Provider type	Employment category			Total
	Military	Civilian	Contract	
Psychiatrist	199	140	91	430
Psychologist	239	980	78	1,297
Mental health nurse practitioner	37	47	20	104
Mental health registered nurse	91	117	13	221
Social worker	273	1,298	107	1,678
Other licensed provider	0	0	0	0
Total	839	2,582	310^a	3,731^a

Source: GAO analysis of Department of Defense data. | GAO-15-184.

^aNumbers do not total due to rounding to the nearest number of full-time equivalent positions.

Table 2: Total Number of Air Force Mental Health Providers as of September 2013

Provider type	Employment category			Total
	Military	Civilian	Contract	
Psychiatrist	132	5	9	146
Psychologist	247	14	103	364
Mental health nurse practitioner	26	0	0	26
Mental health registered nurse	39	53	28	120
Social worker	231	143	117	491
Other licensed provider	0	0	0	0
Total	675	215	257	1,147

Source: GAO analysis of Department of Defense data. | GAO-15-184.

Table 3: Total Number of Navy Mental Health Providers as of September 2013

Provider type	Employment category			Total
	Military	Civilian	Contract	
Psychiatrist	109	38	28	175
Psychologist	144	103	93	340
Mental health nurse practitioner	32	2	9	43
Mental health registered nurse	71	14	68	153
Social worker	51	89	66	206
Other licensed provider	0	23	31	54
Total	407	269	295	971

Source: GAO analysis of Department of Defense data. | GAO-15-184.

Table 4: Total Number of National Capital Region (NCR) Medical Directorate Mental Health Providers as of September 2013

Provider type	Employment category			Total
	Military ^a	Civilian	Contract	
Psychiatrist	0	51	6	57
Psychologist	0	56	22	78
Mental health nurse practitioner	0	0	0	0
Mental health registered nurse	0	40	18	58
Social worker	0	86	33	119
Other licensed provider	0	16	10	26
Total	0	249	89	338

Source: GAO analysis of Department of Defense (DOD) data. | GAO-15-184.

^aThe NCR Medical Directorate was initially established as a DOD joint task force in September 2007 to operate DOD's medical facilities in the national capital region—including Walter Reed National Military Medical Center, Fort Belvoir Community Hospital, and supporting clinics. The NCR Medical Directorate reassigned civilian and contract personnel from the military services to the NCR Medical Directorate while retaining military mental health providers within the appropriate military services' figures.

Appendix II: Recruitment and Retention of Department of Defense Mental Health Providers

This appendix provides information on the recruitment and retention of Department of Defense (DOD) mental health providers. Specifically, we discuss (1) the mechanisms the military services use to recruit and retain mental health providers, and (2) the challenges the military services experience in recruiting and retaining mental health providers.

To determine the mechanisms the military services use to recruit and retain mental health providers, we reviewed relevant laws, including each National Defense Authorization Act (NDAA) from fiscal years 2010 through 2014, to determine the recruitment and retention mechanisms available to DOD for mental health providers. We also spoke with officials from Office of the Assistant Secretary of Defense for Health Affairs (OASD HA), Army, Air Force, and Navy about their use of these mechanisms.

To determine the challenges the military services experience in recruiting and retaining mental health providers, we spoke with officials from OASD HA, Army, Air Force, and Navy. We also reviewed the Health Resources and Services Administration's Health Professional Shortage Area designations to determine whether other health care delivery systems also experienced challenges in recruiting and retaining certain mental health providers.¹

¹The Health Resources and Services Administration is an agency of the Department of Health and Human Services and is the primary federal agency charged with improving access to health care by strengthening the health care workforce, building healthy communities, and achieving health equity. The Health Resources and Services Administration designates certain areas of the nation as Health Professional Shortage Areas.

Military Services Use Numerous Mechanisms to Recruit and Retain Mental Health Providers

All three military services reported using numerous recruitment and retention mechanisms, many of which are cited in the NDAA for Fiscal Year 2010. These mechanisms include the following:²

- **Health Professions Scholarship and Financial Assistance Program (HPSP).** Officials from all three military services reported using this program to recruit various types of medical providers, including mental health providers. Through HPSP, the military services provide scholarships, stipends, and other benefits for students in advanced health care fields—including physicians, psychiatric nurse practitioners, and psychologists.³ The military services reported that HPSP was a particularly important recruitment tool for physicians, including psychiatrists. However, officials from all three military services stressed that they cannot predict the exact number of psychiatrists HPSP will produce annually because it begins funding medical students' general training prior to their selection of a specialty.
- **Uniformed Services University of the Health Sciences (USUHS).** All three military services reported that USUHS was a mechanism for recruiting and training clinical psychologists. USUHS trains, educates, and prepares military health providers, including clinical psychologists, to work in the military health system (MHS).⁴ Officials from the military services reported that the annual enrollment in USUHS for clinical

²The NDAA for Fiscal Year 2010 also included a number of other recruitment and retention mechanisms not highlighted in this report. These additional mechanisms included the expansion of DOD's capacity to train masters-level clinical psychologists and social workers with expertise in deployment-related mental health disorders, detailing commissioned officers to accredited schools of psychology for training leading to a doctoral degree in clinical psychology or social work, and reassigning military mental health providers from administrative to clinical positions.

³Qualifying HPSP students receive (1) full tuition for any accredited medical, psychiatric nurse practitioner, or psychology program; (2) a monthly stipend during the period of academic instruction; (3) officer's pay during academic breaks while training in DOD facilities; and (4) credit for time spent in educational training and placement in the appropriate rank as though this time was spent in active duty military service. Scholarship recipients incur a 1-year active duty military service obligation for each year they receive HPSP scholarship payments, and minimum service obligations differ by health care field. Additional active duty service obligations may be incurred for residency and fellowship training.

⁴Generally, USUHS students do not pay tuition and receive full salary and benefits for a junior officer (second lieutenant or ensign) in exchange for a 7-year active duty military service commitment.

psychology students by service is Army, three students; Air Force, two to three students; and Navy, five students.

- **Bonuses for mental health providers.** Officials from all three military services reported using a variety of bonuses for mental health providers.⁵ Specifically, the Army reported using accession, relocation, and retention bonuses for both military and civilian mental health providers. The Air Force reported that they provide accession bonuses to fully-qualified military mental health providers, as well as bonuses for specialty board certification and a retention bonus after providers have completed a specified number of years-of-service. Finally, the Navy reported that all mental health specialties are eligible for some combination of accession and retention bonuses and board certification pay.
- **Direct-hire authority for civilian mental health providers.** Both the Army and Navy reported using direct-hire authority to recruit civilian mental health providers. The Office of Personnel Management can grant direct-hire authority to executive branch agencies to fill vacancies when a critical hiring need or severe shortage of candidates exists. Direct-hire authorities expedite hiring by eliminating some competitive hiring procedures, such as rating and ranking candidates, that would otherwise be required. Agencies may also pursue agency-specific direct-hire authorities.
- **Training program for licensed clinical social workers.** Both the Army and Navy reported using the Army's training program for licensed clinical social workers. In 2008, the Army created a program for training licensed clinical social workers with Fayetteville State University to address a shortage of Army social work military providers. This program provides participants with a Masters in Social Work and internship placements. The program annually trains up to 30 Army social work military providers, 5 Army National Guard social

⁵Accession bonuses may be offered to certain new military servicemembers, including mental health providers. Retention bonuses, referred to in applicable laws and regulations as allowances, may be offered to existing military servicemembers and to current civilians, including mental health providers, if DOD determines that they have high or unique qualifications or DOD has a special need for the providers' services that makes it essential to retain them and the providers would be likely to leave federal service if a retention incentive was not offered. Relocation bonuses may be offered to current civilians, including mental health providers, who must relocate to accept positions in a different geographic area if the agency determines that their positions are likely to be difficult to fill in the absence of incentives.

work military providers, and 2 Navy social work military providers.⁶ Army officials reported that this program is satisfying all of its need for social work military providers annually, and Navy officials told us that this program was an important recruitment tool for their social work military providers as well.

Military Services Experience Several Challenges Recruiting and Retaining Mental Health Providers

In the face of nationwide shortages of mental health professionals, the ability to recruit and retain mental health providers, particularly psychiatrists, poses a challenge according to officials from all three military services. The Health Resources and Services Administration has reported nationwide shortages of psychiatrists and identified 3,900 health professional shortage areas throughout the nation with a relative scarcity of psychiatrists.⁷ As of January 2014, the Health Resources and Services Administration reported that it would take approximately 2,600 additional psychiatrists nationwide to eliminate the current shortages it has identified.

In addition to nationwide shortages of mental health professionals, there are other overarching military-specific challenges for all three military services as they compete for scarce mental health resources. Mental health provider recruitment and retention challenges specific to military service include:

- **Frequent deployments and relocations.** Officials from all three military services reported that both frequent deployments and relocations made it difficult for them to recruit and retain mental health military providers. For example, Navy officials told us that they have received feedback from psychiatrists leaving military service that requirements to move frequently and deploy were reasons they were leaving the Navy.

⁶An Army official told us that the Army has begun discussions with the Air Force to train a small number of Air Force social work military providers through this program as well.

⁷The Health Resources and Services Administration designates certain areas of the nation as Health Professional Shortage Areas. Health Professional Shortage Areas may be urban or rural areas, population groups, or medical or other public facilities. In order for an area to be designated as a mental health Health Professional Shortage Area, there must be a psychiatrist to population ratio of at least 1: 30,000. In other words, when there are 30,000 or more people per psychiatrist, an area is eligible to be designated as a mental health Health Professional Shortage Area.

- **Assignment to work in remote locations.** According to officials from all three military services, the remote locations where many military treatment facilities are located posed recruitment and retention challenges for mental health providers. For example, Army officials explained that many Army bases are located relatively far away from major metropolitan areas and that mental health military, civilian, and contract providers are reluctant to be located in what they perceived to be remote and isolated locations for lengthy periods of time.
- **Competitive compensation for mental health providers.** Officials from all three military services reported that the inability of DOD to create compensation packages for civilian mental health providers, particularly psychiatrists, that were competitive with private sector compensation affected their ability to recruit and retain these providers. For example, Army officials stated that both a 3-year long DOD pay freeze and recent furloughs affected their ability to create competitive salaries for providers and contributed to the Army's 15 percent turnover rate in their psychiatrist and psychologist mental health provider populations in recent years.

Appendix III: Mental Health Provider Staffing Increases by Military Service

This appendix provides results from our analysis of Department of Defense (DOD) quarterly mental health staffing reports for fiscal years 2009 and 2013. Each service and the National Capital Region (NCR) Medical Directorate submits these reports to the Defense Health Agency (DHA) through the Office of the Assistant Secretary of Defense for Health Affairs (OASD HA) human capital office each quarter to identify their mental health staffing levels. The NCR Medical Directorate is not represented in this appendix because in fiscal year 2009 mental health provider staffing levels were included in the military service totals and, as a result, comparisons of NCR Medical Directorate staffing levels from fiscal year 2009 to fiscal year 2013 are not available.

- Table 5 provides results for mental health provider staffing levels for the Army in fiscal year 2009 and fiscal year 2013.
- Table 6 provides results for mental health provider staffing levels for the Air Force in fiscal year 2009 and fiscal year 2013.
- Table 7 provides results for mental health provider staffing levels for the Navy in fiscal year 2009 and fiscal year 2013.

Table 5: Total Number of Army Mental Health Providers, Fiscal Year 2009 Compared to Fiscal Year 2013

Provider type	Employment category							
	Military		Civilian		Contract		Total	
	Fiscal year		Fiscal year		Fiscal year		Fiscal year	
	2009	2013 ^a	2009	2013 ^a	2009	2013 ^a	2009	2013 ^a
Psychiatrist	126	199	118	140	92	91	336	430
Psychologist	187	239	579	980	110	78	876	1,297
Mental health nurse ^b	102	128	140	164	31	33	273	325
Social worker	125	273	882	1,298	175	107	1,182	1,678
Other licensed provider	0	0	0	0	55	0	55	0
Total	540	839	1,719	2,582	463	310 ^c	2,721 ^c	3,731 ^c

Source: GAO analysis of Department of Defense (DOD) data. | GAO-15-184.

^aFiscal year 2013 values do not include civilian and contract providers assigned to military treatment facilities and subordinate clinics within the National Capital Region Medical Directorate because beginning in fiscal year 2011 this command began reporting as a separate entity.

^bThe mental health nurse category includes both mental health nurse practitioners and mental health registered nurses. In fiscal year 2009, DOD did not report separate employment information on these two types of mental health providers.

^cNumbers do not total due to rounding to the nearest number of full-time equivalent positions.

**Appendix III: Mental Health Provider Staffing
Increases by Military Service**

Table 6: Total Number of Air Force Mental Health Providers, Fiscal Year 2009 Compared to Fiscal Year 2013

Provider type	Employment category						Total	
	Military		Civilian		Contract			
	Fiscal year		Fiscal year		Fiscal year		Fiscal year	
	2009	2013 ^a	2009	2013 ^a	2009	2013 ^a	2009	2013 ^a
Psychiatrist	136	132	2	5	5	9	143	146
Psychologist	214	247	10	14	112	103	336	364
Mental health nurse ^b	38	65	57	53	2	28	97	146
Social worker	220	231	141	143	66	117	427	491
Other licensed provider	0	0	0	0	0	0	0	0
Total	608	675	210	215	185	257	1,003	1,147

Source: GAO analysis of Department of Defense (DOD) data. | GAO-15-184.

^aFiscal year 2013 values do not include civilian and contract providers assigned to military treatment facilities and subordinate clinics within the National Capital Region Medical Directorate because beginning in fiscal year 2011 this command began reporting as a separate entity.

^bThe mental health nurse category includes both mental health nurse practitioners and mental health registered nurses. In fiscal year 2009, DOD did not report separate employment information on these two types of mental health providers.

Table 7: Total Number of Navy Mental Health Providers, Fiscal Year 2009 Compared to Fiscal Year 2013

Provider type	Employment Category						Total	
	Military		Civilian		Contract			
	Fiscal year		Fiscal year		Fiscal year		Fiscal year	
	2009	2013 ^a	2009	2013 ^a	2009	2013 ^a	2009	2013 ^a
Psychiatrist	97	109	27	38	49	28	173	175
Psychologist	106	144	100	103	102	93	308	340
Mental health nurse ^b	69	103	13	16	118	77	200	196
Social worker	22	51	99	89	59	66	180	206
Other licensed provider	0	0	18	23	4	31	22	54
Total	294	407	257	269	332	295	883	971

Source: GAO analysis of Department of Defense (DOD) data. | GAO-15-184.

^aFiscal year 2013 values do not include civilian and contract providers assigned to military treatment facilities and subordinate clinics within the National Capital Region Medical Directorate because beginning in fiscal year 2011 this command began reporting as a separate entity.

^bThe mental health nurse category includes both mental health nurse practitioners and mental health registered nurses. In fiscal year 2009, DOD did not report separate employment information on these two types of mental health providers.

Appendix IV: Comments from the Department of Defense



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

DEC 12 2014

Mr. Randy Williamson
Director, Health Care
U.S. Government Accountability Office
441 G Street, N.W.
Washington, DC 20548

Dear Mr. Williamson,

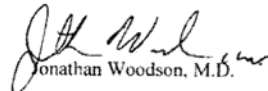
This is the Department of Defense response to the Government Accountability Office (GAO) Draft Report, GAO-15-184, "DEFENSE HEALTH CARE: Additional Information Needed About Mental Health Provider Staffing Needs," dated November 10, 2014 (GAO Code 291218).

Thank you for the opportunity to review and provide comments on the draft report. We sent the draft to the Services for their comments and have included those comments to the response (enclosed). We have reviewed the report for technical accuracy and do not agree with the findings and some of the recommendations (enclosure).

Of the four recommendations, we non-concur with any recommendation to require the Services to include PHRAMS in the requirements field of the quarterly reports. We have collected these reports since 2009 and since the Services do not use PHRAMS as the sole source of mental health requirements, it will not add value to require that data element in the quarterly report.

My points of contact are Ms. Rebecca Russell (Functional) who may be reached at (703) 681-8805, or rebecca.russell@ha.osd.mil and Mr. Gunther Zimmerman (Audit Liaison) who may be reached at (703) 681-3492, or gunther.zimmerman@dha.mil.

Sincerely,


Jonathan Woodson, M.D.

Enclosures:
As stated

GAO Draft Report Dated November 7, 2014
GAO-15-184 (GAO CODE 291218)

**"DEFENSE HEALTH CARE: ADDITIONAL INFORMATION NEEDED ABOUT
MENTAL HEALTH PROVIDER STAFFING NEEDS"**

DEPARTMENT OF DEFENSE COMMENTS

RECOMMENDATION #1:

To ensure DHA can accurately and consistently assess mental health provider staffing needs across each of the military services, we recommend that the Secretary of Defense direct the Secretaries of the Army, Air Force, and Navy to take the following two actions:

- Require the medical commands of each military service to report any additional service-specific methods they use to determine their final estimates of mental health provider staffing needs; and
- Require the medical commands of each military service to include their estimated mental health provider staffing needs generated through PHRAMS in the requirements fields of DHA's quarterly mental health staffing reports.

DoD RESPONSE:

- We concur with the recommendation that the medical commands of each military service include any additional Service-specific methods they use to determine final estimates of mental health provider staffing needs.
- We do not concur with this recommendation. Using PHRAMS in the requirements fields will not add value to the quarterly mental health staffing reports.

RECOMMENDATION #2:

We further recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to take the following two actions:

- Ensure DHA, through the PHRAMS contractor, continue to refine PHRAMS to incorporate the needs of the military services to reduce the need for additional service-specific methods of determining mental health provider staffing needs; and

- Require the NCR Medical Directorate to include their estimated mental health provider staffing needs generated through PHRAMS in the requirements fields of DHA's quarterly mental health staffing reports.

DoD RESPONSE:

- The DHA continues to serve in an advisory role to the Services to ensure the next version of PHRAMS meets the needs of the each Service. Service leaders and DHA leadership will provide guidance and milestones to ensure timely metrics are met.
- We do not concur with this recommendation. Using PHRAMS in the requirements fields will not add value to the quarterly mental health staffing reports.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Randall B. Williamson, (202) 512-7114 or williamsonr@gao.gov.

Staff Acknowledgments

In addition to the contact named above, Marcia A. Mann, Assistant Director; A. Elizabeth Dobrenz; Mary Giffin; Cathleen Hamann; Katherine Nicole Laubacher; Vikki Porter; Dharani Ranganathan; and Laurie F. Thurber made key contributions to this report. Jacquelyn Hamilton provided legal support.

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